11993

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85)

CERTIFICATE OF DEATH

Reg. Dist. No. 96 O

1. PLACE OF DEATH:

County: CECIL

City or town: Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs. 4 mos. 27 days

Hospital, institution, or street address where death occurred:
Veterans Administration Hospital, Perry Point, Md.

How long in hospital or institution? 3 yrs. 4 mos. 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Belmont Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: Spanish American & Peace Time

3. (a) FULL NAME: ARNDT, Paul E.

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Minnie Arndt

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 1, 1880

8. AGE:

Years	Months	Days	If less than one day
66	8	26	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Blacksmith

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital records

Address

17. Removal Date thereof: Dec. 28, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Unknown

Location

19. Funeral director: Pennington & Son

Address: PENNINGTON & SON, Havre de Grace, Md.

19. Dec 28 19 46 Irene E. Dougherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 27 19 46 at 6:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30 19 43 to Dec. 27 19 46 and that I last saw him alive on December 27 19 46

Immediate cause of death: General Arteriosclerosis — Duration: Over 6 yrs.

Due to:

Due to:

Other conditions: 1. Psychosis with cerebral arteriosclerosis; 2. Epilepsy
(Include pregnancy within 3 months of death)

Major findings of operations: --

Date of op.

Autopsy results: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work?

23. SIGNATURE: A. E. Trollinger
A. E. TROLLINGER, M.D., Clinical Director
Veterans Administration
Address: Perry Point, Md. Date signed: 12-28-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

11994

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 960

1. PLACE OF DEATH:
County: Cecil
City or town: Port Deposit, Rural,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Port Deposit, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Conowingo, Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Lillie May Benjamin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Hazlett O. Benjamin
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): November 2, 1877

8. AGE:

Years	Months	Days	If less than one day
69	2	22	hrs. min.

9. Birthplace: North East, Cecil Co., Md.
(Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business

FATHER
12. Name: Benjamin F. Chambers
13. Birthplace: Cecil Co., Md.

MOTHER
14. Maiden name: Lillie Davis
15. Birthplace: Cecil Co., Md.

16. Informant: H.O. Benjamin Jr.
Address: Port Deposit, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 31, 1946 (month) (day) (year)
Cemetery or crematory: Hopewell
Location: Port Deposit, Md. Rural

18. Funeral director: Leo A. Patterson & Son
Address: Perryville, Md.

19. Dec. 31 1946 Irene E. Dougherty
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 28 1946 at 5.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26 1945 to Dec 20 1946.
and that I last saw h. alive on Dec-20 1946.

Immediate cause of death	DURATION
Cerebral Hemorrhage -	Few minutes
Due to Hypertension	3 yrs
Due to Arterio Sclerosis -	3 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: E. W. Broom M.D. M. D. or other
Address: Port Deposit Md. Date signed 12/30/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-a)

CERTIFICATE OF DEATH

11995

Reg. Dist. No. 920

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 days

Hospital, Institution, or street address where death occurred: Union Hospital

How long in hospital or institution? 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Elkton Rural (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Daisy Bouchelle

3.(b) Social Security Number none

4. Sex Female

5. Color or race White

6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife James P. Bouchelle

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 7 - 1884

8. AGE: Years 62 Months 10 Days 16 If less than one day hrs. min.

9. Birthplace (Town, county, and state) Chesapeake City Md

10. Usual occupation none

11. Industry or business

FATHER **12. Name** James Moore

13. Birthplace Md

MOTHER **14. Maiden name** Mary Booth

15. Birthplace Md

16. Informant James P. Bouchelle

Address North East Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-26-46 (month) (day) (year)

Cemetery or crematory Methodist

Location North East, Md

18. Funeral director Joseph R. Frazier

Address North East, Md

19. Dec 26 1946 (Date rec'd by registrar) F R Frazier Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 - 1946 at 7.23 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 24 - 1946 to Dec 23, 1946 and that I last saw h. alive on Dec 22 - 1946

Immediate cause of death	DURATION
Depsia & gene uremia	
Due to Intestinal Obstruction	
Due to Sleamyloid of Myocardial Worm	
Other conditions Fecal fistula	

(Include pregnancy within 3 months of death)

Major findings of operations Sleamyloidosis of bowel w/ Ileum Resection Date of op. Nov 24/46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. C. Cantwell M.D. M. D. or other

Address Elkton Md Date signed Dec 24/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

11996

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Perryville Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 57 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Perryville, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Frenchtown Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Francis Blan Boyd

3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: William H. Boyd
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Jan. 4, 1873

8. AGE: Years 73 Months 11 Days 6 If less than one day: hrs. min.

9. Birthplace: Philadelphia, Pa (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business
FATHER 12. Name: William Hackney
13. Birthplace: Philadelphia Pa
MOTHER 14. Maiden name: Mary Murphy
15. Birthplace: Pa.
16. Informant: Edna Tilton
Address: Perryville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 13, 1946 (month) (day) (year)
Cemetery or crematory: Asbury
Location: Port Deposit, Md. Rural
18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.
19. Dec. 12 1946 Irene E. Daughaday (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 10 1946 at 12.20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1st 1946, to Dec. 10th 1946 and that I last saw him alive on December 10th 1946

Immediate cause of death	DURATION
Cerebral Haemorrhage	3 da.
Due to: General Atheromata with hypertension	5 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. F. Magraw M. D. or ~~other~~
Address: Perryville, Md. Date signed: 12/11/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11997

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 minutes.
Hospital, institution, or street address where death occurred: Union Hospital Elkton Md
How long in hospital or institution? 30 minutes.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: N.J. County:
City or town: Camden.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2750 Carman St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME Edward Brand.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Catherine Brand
6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Sept 29 1887

8. AGE: Years 59 Months 2 Days 8 If less than one day ... hrs. ... min.

9. Birthplace: Camden N J (Town, county, and state)
10. Usual occupation: Capt Ferry Boat
11. Industry or business:
FATHER 12. Name: Charles Brand
13. Birthplace: Camden. N J
MOTHER 14. Maiden name: Unknown
15. Birthplace: Unknown
16. Informant: Charles Brand
Address: Penns Grove N J
17. Removed (Burial, cremation, or removal. Which?) Date thereof: Dec 9 '46 (month) (day) (year)
Cemetery or crematory: Arlington Camden
Location: Merchantville N J
18. Funeral director: J. W. Lippincott
Address: Elkton Md
19. Dec 9 1946 (Date rec'd by registrar) F. R. Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 7 1946 at 9:23 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw it alive on ... 19...

Immediate cause of death	DURATION
Angina	
Pectoris	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. H. Dodson M.D. M. D. or other
Address: Rising Sun Md Date signed: 12-7-46

Medical Examiner for Cecil County

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12565

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: PERRY POINT, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos. 2 days

Hospital, institution, or street address where death occurred:
Veterans Administration Hospital, Perry Point, Maryland

How long in hospital or institution? 3 mos. 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5 Pleasant Court
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3. (a) FULL NAME
BROWN, Richard

3. (b) Social Security Number
Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Mrs. Alice L. Brown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 27, 1890

8. AGE: Years	Months	Days	If less than one day
56	10	26	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Charles Brown, deceased
13. Birthplace: Anne Arundel Co., Md.

MOTHER
14. Maiden name: Eliza Neal - deceased
15. Birthplace: Anne Arundel Co., Md.

16. Informant: Hospital Records

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Dec. 24, 1946 (month) (day) (year)

Cemetery or crematory: Annapolis, Maryland

Location: Annapolis National Cemetery

18. Funeral director: Mrs. Ethel L. Hicks Per. Chas. E. Hicks
MRS. ETHEL L. HICKS

Address: 45 Northwest Street, Annapolis, Md.

19. Dec 24 1946 Irene E. Daughtry
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 23 1946 at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 21 1946 to December 23, 1946 and that I last saw him alive on December 23 1946

Immediate cause of death	DURATION
Hemorrhage, cerebral	One week
Due to	
Due to	
Other conditions: General Paralysis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: --

Date of op.: --

Autopsy results: Cerebral hemorrhage

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: Injured at work?

23. SIGNATURE: A. E. Trollinger M. D. or other
A. E. TROLLINGER, M.D., Clinical Director

Address: Perry Point, Md. Date signed: 12-24-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

★ 11998

Reg. Dist. No. 926

1. PLACE OF DEATH:

County: Cecil

City or town: Rural Near Elkton, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 years

Hospital, institution, or street address where death occurred: Elkton R.D. 5

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Rural Near Elkton, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Elkton R.D. 5, Md

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Gideon M. Clark

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Wh	Married.

6.(b) Name of husband or wife: Alberta D. Clark

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): Feb. 21, 1869

8. AGE:

Years	Months	Days	If less than one day
77	9	27	hrs. min.

9. Birthplace: Delaware (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER

12. Name: James Clark

13. Birthplace: Cecil Co Md

MOTHER

14. Maiden name: Sophie Spry

15. Birthplace: Kent Co. Md

16. Informant: Mr. Reese Clark

Address: Elkton R.D. 5, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 22/46 (month) (day) (year)

Cemetery or crematory: Bethel Near Chesapeake City Md

Location: Chesapeake City RD. Md

18. Funeral director: H. W. Pepper

Address: Elkton, Md.

19. Dec 21 1946 (Date rec'd by registrar) F. R. Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 20th 1946 at 3.15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1946 to Dec 20th 1946 and that I last saw h. alive on Dec. 19th 1946

Immediate cause of death	DURATION
Cerebral Embolism	5 days
Due to: Chronic Myocarditis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Jesse J. Greenwald M.D. M. D. or other

Address: Elkton Md Date signed: DEC 21 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

11999

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 960

1. PLACE OF DEATH:

County: Cecil

City or town: U.S.N.T.C., Bainbridge, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, Institution, or street address where death occurred:
U.S.N.T.C., Bainbridge, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: West Virginia County:

City or town: Bluefield, West Virginia
(If outside city or town limits, write RURAL and give nearest town)

Street No. 201 Floyd Street
(If rural, give LOCATION)

2.(a) If veteran, name war: U.S. Navy, World War II

3.(a) FULL NAME

COLLINS, William

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 4/6/24

8. AGE:

Years	Months	Days	If less than one day
22	8	25	..... hrs. ..... min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual occupation: U. S. Navy

11. Industry or business: U. S. Navy

FATHER
12. Name: Not Available
13. Birthplace

MOTHER
14. Maiden name: Mrs. Katharine Harmon Collins
15. Birthplace: Not Available

16. Informant: U. S. Navy

Address: USNTC, Bainbridge, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Jan. 3, 1947 (month) (day) (year)

Cemetery or crematory:

Location: To Bluefield, Mercer Co., West Va.

18. Funeral director: Wm. A. Patterson & Son.

Address: Perryville, Maryland

19. Jan. 3 1947 (Date rec'd by registrar) Irene E. Dougherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 31 December 1946 at 5:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 31 December 1946, to 31 December 1946 and that I last saw him alive on 31 December 1946

Immediate cause of death: Fracture dislocation of cervical spine.

	DURATION
Immediate cause of death: Fracture dislocation of cervical spine.	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Fracture dislocation cervical spine.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 31 Dec. 1946

Where did injury occur? USNTC Bainbridge (City or town) Cecil (County) Md. (State)

Injured at home, farm, industry, public place (where?): USNTC, Bainbridge, Md.

Means of injury: Auto accident Injured at work? yes

23. SIGNATURE: R. E. Dodson M.D. M. D. or other

Address: Perryville Md. Date signed: 12/31-46

Medical Examiner
Cecil County

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14a)

CERTIFICATE OF DEATH

12000

Reg. Dist. No. 960

1. PLACE OF DEATH:
County: Cecil
City or town: Principio Furnace, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Principio Furnace, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: John Russell Currier

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Oct. 6, 1882

8. AGE: Years: 64 Months: 1 Days: 25 If less than one day hrs. min.

9. Birthplace: Principio Furnace, Cecil, Md. (Town, county, and state)
10. Usual occupation: Painter
11. Industry or business: House

FATHER
12. Name: William H. Currier
13. Birthplace: Cecil Co., Md.

MOTHER
14. Maiden name: Martha Jane Russell
15. Birthplace: Harford Co., Md.

16. Informant: R. O. Currier
Address: Perryville, Md. Rural.
17. Buried St. Marks (Burial, cremation, or removal. Which?) Date thereof: Dec. 4, 1946 (month) (day) (year)
Cemetery or crematory: St. Marks
Location: Perryville, Md. Rural
18. Funeral director: Leo A. Patterson & Son
Address: Perryville, Md.
19. Dec 3 1946 (Date rec'd by registrar) Irene E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 1st 1946 at 6a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 29 1946 to Dec. 1st 1946 and that I last saw him alive on November 30 1946

Immediate cause of death	DURATION
Coronary Thrombosis	Immediate
Due to: General Atherosclerosis	3 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. F. Magnan M. D. ~~other~~
Address: Perryville Md Date signed: Dec. 3 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

* 12001

1. PLACE OF DEATH (46-2)

County: Cecil — Registration Dist. No. 900

Village or City: Ceciltown Md. — No. ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred: 41 yrs. ____ mos. ____ ds. How long in U.S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Cornelius W. Davis — If U. S. Veteran, specify WAR ____

(a) Residence: No. Ceciltown Md. St., ____ Ward. ____
(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mannie E. Pierce

6. DATE OF BIRTH (month, day, and year): Jan 28 1878.

7. AGE: Years 68 | Months | Days | If LESS than 1 day, ____ hrs. or ____ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Farming.
9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: ____
10. Date deceased last worked at this occupation (month and year): May 1946
11. Total time (years) spent in this occupation: all of life

12. BIRTHPLACE (city or town) (State or country): Delaware

FATHER

13. NAME: Cornelius W. Davis
14. BIRTHPLACE (city or town) (State or country): Delaware

MOTHER

15. MAIDEN NAME: Mary E. Draper
16. BIRTHPLACE (city or town) (State or country): Delaware

17. INFORMANT: Mrs Cornelius Davis
(Address): Ceciltown Md.

18. BURIAL, CREMATION, OR REMOVAL
Place: Fairview — Date: Dec 10, 1946

19. UNDERTAKER: G. Tester Daniels
(Address): Townsend Del.

20. FILED: 12/8, 1946 — Mrs Harold W. Cheyney, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH December (Month) 7th (Day), 1946 (Year)

22. I HEREBY CERTIFY, That I attended deceased from May 1, 1946, to Dec. 7, 1946

I last saw him alive on Dec. 6, 1946, death is said to have occurred on the date stated above, at 2:10 a.m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Cancer:	unknown
Primary in intestine. Cause	
Duration: two years.	

Other **Contributary Causes** of Importance: unknown

Name of operation ____ Date of ____

What test confirmed diagnosis? ____ Was there an autopsy? ____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Date of Injury ____, 19____

Where did injury occur? ____
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, In HOME, or In PUBLIC PLACE.

Manner of Injury ____

Nature of Injury ____

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify ____

(Signed) J. D. Miles M. D.

(Address) Middletown Del.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

V. S. No. 1

I

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 12002 920

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11-30-46 to 12-10-46

Hospital, institution, or street address where death occurred: Union Hospital

How long in hospital or institution? 11-30-46 to 12-10-46

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)

Street No.: E. Main St. Mrs. S. McKeever
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Elizabeth Fisher Gerry

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband or wife: Strawbridge Gerry

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Nov 14, 1862

8. AGE: Years 84 Months 0 Days 26 If less than one day ____ hrs. ____ min.

9. Birthplace: Cecil Co. Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: John Fisher
13. Birthplace: Port Deposit, Md.

MOTHER
14. Maiden name: Anna Murphy
15. Birthplace: Port Deposit, Md.

16. Informant: Eleanor McKeever
Address: Elkton, R.D. # 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 13. 1946 (month) (day) (year)

Cemetery or crematory: West Nottingham

Location: Colora Md.

18. Funeral director: J. E. Tyson

Address: Rising Sun, Md.

19. Dec 11 1946 (Date rec'd by registrar) F.R. Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 December 1946 at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 November 1946 to 10 December 1946 and that I last saw h.e. alive on 10 December 1946

Immediate cause of death	DURATION
Cardiac Failure (Decompensated)	10 Days
Due to: Acute Lobar Pneumonia	12 days
Due to:	
Other conditions: Possible Acute Cholecystitis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: George Gheen Jr. M. D. or other

Address: 301 E Main Street Date signed: 10 Dec. '46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-6)

CERTIFICATE OF DEATH

12003

Reg. Dist. No. 920

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred: 110 Milburn St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DEACESED: (For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Elkton (If outside city or town limits, write RURAL and give nearest town)

Street No.: 110 Milburn St (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William H. Gibson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Ruth Gibson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 17, 1873

8. AGE:

Years	Months	Days	If less than one day
73			..... hrs. ..... min.

9. Birthplace (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER

12. Name: William Gibson

13. Birthplace: Md.

MOTHER

14. Maiden name: Elizabeth Bratton

15. Birthplace: Md.

16. Informant: Lula Sullivan

Address: 726 Buttonwood St. Phila. Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/24/46 (month) (day) (year)

Cemetery or crematory: Providence Cemetry

Location: Elkton, Maryland

18. Funeral director: Edwin R. Bell

Address: 909 Poplar St. Wilmington, Del.

19. Dec 23 1946 (Date rec'd by registrar) F R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 23 1946, at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 11 1946, to December 23 1946 and that I last saw h... alive on December 23 1946

Immediate cause of death: Acute Dilatation of heart — DURATION

Due to: Aortic heart failure — 8 yrs.

Due to:

Other conditions: Chr. pneumonitis, nephritis — 8 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: James J. Johnson M.D. (M. D. or other)

Address: Elkton, Md. Date signed: 12/23/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12004

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs. 8 mos. 18 das.

Hospital, institution, or street address where death occurred:
Veterans Adm. Hospital, Perry Point, Md.

How long in hospital or institution? Since Feb. 1, 1939

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Landover
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.F.D. #1
(If rural, give LOCATION)

2.(a) If veteran, name war: Spanish American War

3. (a) FULL NAME: HART, Cyrus S.

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): May 24, 1860

8. AGE: Years	Months	Days	If less than one day
86	6	18	hrs. min.

9. Birthplace: California, Mo. (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: Unknown

FATHER
12. Name: Charles Hart - Deceased
13. Birthplace: Penn.

MOTHER
14. Maiden name: Elizabeth Brannon - deceased
15. Birthplace: Ohio

16. Informant: Hospital Records

Address: Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 12-13-46 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Md.

18. Funeral director: Pennington & Son

Address: PENNINGTON & SON, Havre de Grace, Md.

19. Dec. 13 1946 (Date rec'd by registrar) Irene E. Dougherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 12 1946 at 3:35 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 24, 1942 to December 12 1946 and that I last saw him alive on December 12 1946

Immediate cause of death	DURATION
Tuberculosis, Pulmonary, Far Advanced, Chronic,	over 4 yrs
Due to	
Due to	
Other conditions: Psychosis w/cerebral arteriosclerosis (Include pregnancy within 3 months of death)	unknown

Major findings of operations: ---

Date of op.

Autopsy results: Valvular heart disease, arterio-sclerotic; arteriosclerosis; Tbc. Pulm.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work? --

23. SIGNATURE: A. E. Trollinger M. D. or other
A.E. TROLLINGER, M.D., Clin. Director

Address: VAH, Perry Point, Md. Date signed: 12-13-46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46B)

CERTIFICATE OF DEATH

12005

Reg. Dist. No. 960

1. PLACE OF DEATH:
County: Cecil
City or town: Perryville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Perryville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mattie C. Henderson

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Howard W. Henderson
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Dec. 25, 1892

8. AGE: Years 53 Months 11 Days 10 If less than one day hrs. min.

9. Birthplace: Havre De Grace, Harford Co. Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: William Price
13. Birthplace: Harford Co., Md
MOTHER 14. Maiden name: Nadoe Orr
15. Birthplace: Fort Deposit Cecil Co. Md
16. Informant: Sarah C. Patterson
Address: Perryville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 7, 1946 (month) (day) (year)
Cemetery or crematory: Asbury
Location: Fort Deposit Md. Rural
18. Funeral director: L. A. Patterson & Son
Address: Perryville, Md.
19. Dec. 7, 1946 Irene E. Dunglinson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5 - 1946 at 3:45 - A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 20 1946 to Dec 5 - 1946 and that I last saw h. alive on Dec - 5 - 1946

Immediate cause of death: Carcinoma of Liver — DURATION 8 months

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. J. Brown M. D. M. D. or other
Address: Port Deposit, Md. Date signed 12/5/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (178-C)

CERTIFICATE OF DEATH

12006

Reg. Dist. No. 91

1. PLACE OF DEATH:

County: Cecil

City or town: Chesapeake City, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? All life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Chesapeake City, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: I

3.(a) FULL NAME William Herbert Herman

3.(b) Social Security Number

4. Sex: M

5. Color or race: White

6.(a) Single, married, widowed, or divorced: widower

6.(b) Name of husband or wife: Mabel Herman

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov 21 1894

8. AGE: Years 52 Months 0 Days 15 If less than one day hrs. min.

9. Birthplace: Chesapeake City, Md (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER 12. Name: David J. Herman

13. Birthplace: Chesapeake City, Md

MOTHER 14. Maiden name: Sarah E. Simpson

15. Birthplace: Elkton Md

16. Informant: Mrs Lorenzo Biddle

Address: 412 North Lemon St Wilmington

17. Burial (Burial, cremation, or removal. Which?) Date thereof: December 9 1946 (month) (day) (year)

Cemetery or crematory: Bethel Cemetery

Location: Bethel Cemetery Chesapeake City, Md RD.

18. Funeral director: H. W. Pippin

Address: Elkton Md

Dec. 9 1946 (Date rec'd by registrar) Mrs Ralph H. Pike Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 6 1946 at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death: Carbon monoxide poisoning from Coal Gas. — DURATION

Due to: Coal Gas.

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 12-6-46

Where did injury occur? Chesapeake City (City or town) Cecil (County) Md (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury: Gas fumes from Oil Stove Injured at work? NO

23. SIGNATURE: R. E. Dodson MD M. D. or other

Address: Rising Sun Md Date signed 12-7-46

Medical Examiner Cecil County

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-1)

12007

CERTIFICATE OF DEATH

Reg. Dist. No. 920

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 do

Hospital, institution, or street address, where death occurred: Union Hospital

How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Elkton R.D. (If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural Near Elkton (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Samuel Holliday

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Wh.	Widowed

6.(b) Name of husband or wife: Mary Holliday 6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Sept 27, 1876

8. AGE: Years	Months	Days	If less than one day
70	2	27	____ hrs. ____ min.

9. Birthplace: Cherry Hill Md (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER 12. Name: John Holliday

13. Birthplace: No Inf.

MOTHER 14. Maiden name: No Inf.

15. Birthplace: No Inf.

16. Informant: Josephine Goodyear

Address: Elkton RD Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 27 '46 (month) (day) (year)

Cemetery or crematory: Elkton

Location: Elkton Md

18. Funeral director: H. W. Pippin

Address: Elkton Md

19. Dec 26 1946 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 23 December 1946 at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 December 1946 to 23 Dec 1946 and that I last saw him alive on 22 December 1946

Immediate cause of death	DURATION
Myocardial Failure	
Due to: Aortic Insufficiency	
Due to: Luetic Aortitis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: Aortic Stenosis Atherosclerosis Coronary vessels

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: George J Kreiss, Jr. M.D. or other

Address: 201 E Main Street Date signed: 23 Dec 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

12008

Reg. Dist. No. 920

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Union Hospital

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No. 131 Milburn St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME ~~Daisy Logan~~ Carrie Logan

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1888

8. AGE: Years 58 | Months | Days | If less than one day hrs. min.

9. Birthplace Hendersonville, N.C. (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name Jerry Logan

13. Birthplace N.C.

MOTHER 14. Maiden name Marriah Waters

15. Birthplace S.C.

16. Informant Robert Logan

Address 131 Milburn St. Elkton, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 12/23/46 (month) (day) (year)

Cemetery or crematory Hendersonville, N.C.

Location

19. Funeral director Edw. R. Bell

Address 909 Poplar St. Wilmington, Del.

19 Dec 23 1946 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20 1946 at 1 5-5 p.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 17 1946 to Dec. 20 1946 and that I last saw him alive on Dec. 20 1946

Immediate cause of death Cardiac failure — DURATION Dec. 20

Due to Gangrene Amputation — left leg, supracondylar.

Due to Gangrene left foot

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations Gangrene of left foot — sclerosis of arteries — Date of op. Dec. 20, 1946

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Milford V. Preacher M. D. or other

Address Elkton, Md. Date signed Dec. 20

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B1a)

CERTIFICATE OF DEATH

Reg. Dist. No. 920 — 12009

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, Institution, or street address where death occurred: 114 Osage St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Elkton,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 114 Osage St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Alfred B. McVey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Wh.	Widowed

6.(b) Name of husband or wife: Leulla McVey
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 14, 1859

8. AGE: Years 87 | Months 5 | Days 19 | If less than one day ..... hrs. ..... min.

9. Birthplace: Zion, Md (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business
FATHER 12. Name: Abraham McVey
13. Birthplace: Zion, Md
MOTHER 14. Maiden name: Margaret McCormick
15. Birthplace: West Nottingham, Md
16. Informant: Mrs Chas. W. McDonald
Address: 114 Osage St Elkton, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 6-1946 (month) (day) (year)
Cemetery or crematory: Zion Presbyterian
Location: Zion, Md
18. Funeral director: H. W. Pippin
Address: Elkton, Md
19. Dec 5 1946 (Date rec'd by registrar) F R Frazier Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 3 1946 at 11 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1925 to Dec 3 1946 and that I last saw him alive on December 3 1946

	DURATION
Immediate cause of death: Acute dilatation of heart	
Due to: Chronic Emphysema	
Due to:	
Other conditions: Chronic Interstitial nephritis, Senility	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J Herbert Bates M. D. (M. D. or other)
Address: Elkton Md Date signed 12/4/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (161-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 120105

1. PLACE OF DEATH:
County: Cecil
City or town: Rowlandville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 Months
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? # 62

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Rowlandville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Kenneth C. Miller

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 25 1946

8. AGE: Years | Months: 6 | Days: 17 | If less than one day: hrs. min.

9. Birthplace: Rowlandville, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Charles W. Graybeal
13. Birthplace: Rising Sun Md.

MOTHER
14. Maiden name: Louis Miller
15. Birthplace: Conowingo Md.

16. Informant: Louis Miller
Address: Rowlandville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 15 1946 (month) (day) (year)
Cemetery or crematory: Baptist Cem
Location: Conowingo Md.

18. Funeral director: J. E. Tyson
Address: Rising Sun Md.

19. Dec 13 1946 (Date rec'd by registrar) L M Worthington Registrar

Permit issued 12-13-46

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 12 1946 at 9A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19
and that I last saw h alive on 19

Immediate cause of death: Strangulation by suicide.

	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 12-12-46
Where did injury occur? Rowlandville Cecil Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: R. E. Dodson M.D. Medical Examiner Cecil County
Address: Rising Sun Md. Date signed 12-13-46 M. D. or other

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

12011

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 56

CERTIFICATE OF DEATH

Reg. Dist. No. 920

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton Rd 4 Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place at death? 20 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Elkton Rd 4
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(c) If veteran, name war: NOT A Veteran

3. (a) FULL NAME: Daniel A. Nungesser

3. (b) Social Security Number: None

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: married

8.(b) Name of husband or wife: Mary Frances Nungesser

6.(c) If alive, give age: 82 years

7. Birth date of deceased (mo., day, yr.): Dec 19 1861

8. AGE: Years: 85 Months: — Days: 11 If less than one day: hrs. min.

9. Birthplace: Troer, Iowa
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: Peter Nungesser
13. Birthplace: Penna

MOTHER 14. Maiden name: Mary Kingman
15. Birthplace: Penna

16. Informant: Frederick D. Nungesser
Address: ELKTON Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1 1 1947 (month) (day) (year)

Cemetery or crematory: Long Prairie Minn

Location: Long Prairie Minn

18. Funeral director: Joseph R. Frauer
Address: North East Md

19. Dec 31 1946 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 30 December 1946 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1946 to 30 Dec. 1946 and that I last saw him alive on 30 Dec. 1946

Immediate cause of death	DURATION
Anemia, secondary, severe	1 year
Due to: Adenocarcinoma of the Prostate	
Due to: —	
—	
Other conditions: —	
—	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: Injured at work? —

23. SIGNATURE: Klaus H Huebner M.D. M. D. or other

Address: North East, Md Date signed: 31 Dec 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-d)

CERTIFICATE OF DEATH

12012

Reg. Dist. No. 94

1. PLACE OF DEATH:

County: Cecil

City or town: North East Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: North East Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: not a veteran

3.(a) FULL NAME Joseph Perovich

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mabel Foreaker Perovich

6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): March 19 1898

8. AGE:

Years	Months	Days	If less than one day
48	9	9	hrs. min.

9. Birthplace: Austria
(Town, county, and state)

10. Usual occupation: Poultry farmer

11. Industry or business: —

FATHER
12. Name: Ambrose Perovich
13. Birthplace: Austria

MOTHER
14. Maiden name: Anna Fromelich
15. Birthplace: Austria

16. Informant: Mrs. Mabel Perovich
Address: North East, Md. (Rural)

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 31 1946 (month) (day) (year)

Cemetery or crematory: Methodist Cemetery

Location: North East, Md.

18. Funeral director: Joseph R. Grant
Address: North East, Md.

19. 12-30 1946 Lida B. Clesene
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 28 1946 at 3 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9 1946 to Dec. 28 1946 and that I last saw him alive on Dec. 28 1946

Immediate cause of death: Carcinoma Left Lung — DURATION: 1 yr.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. B. Collins, M.D. M. D. or other

Address: North East, Md. Date signed: 12.30.46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

12013

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (740)

CERTIFICATE OF DEATH

Reg. Dist. No. 940

1. PLACE OF DEATH:

County: Cecil

City or town: North East, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Residence-North East, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: North East
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Sylvester Preston

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ella May Cullen

6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): May 13, 1866

8. AGE:

Years	Months	Days	If less than one day
80	7	26	hrs. min.

9. Birthplace: Hartford Co. Md.
(Town, county, and state)

10. Usual occupation: Judge - Orphan's Court

11. Industry or business: Farmer

FATHER
12. Name: Benjamin Preston
13. Birthplace: Hartford County

MOTHER
14. Maiden name: Julia Ley
15. Birthplace: Germany

16. Informant: Mrs. Sylvester Preston
Address: North East, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10 Dec. 1946 (month) (day) (year)

Cemetery or ~~crematory~~: Babes
Location: Aberdeen Md

18. Funeral director: Jos. R. Grant
Address: North East, Md.

18. 12-10 (Date rec'd by registrar) 19 46 Lia V. Greene Registrar

MEDICAL CERTIFICATION 12:10

20. DATE OF DEATH: Dec. 7 19 46, at A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 Dec. 1946 19 to 7 Dec. 19 46
and that I last saw him alive on 7 Dec. 19 46

Immediate cause of death: Coronary Occlusion — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: H. C. Cullell M.D. M. D. or other

Address: North East, Md. Date signed: Dec 9/1/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 12019 94

1. PLACE OF DEATH:
County: Cecil
City or town: North East Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: North East Rural.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Charles Edward Rhoades. Jr

3. (b) Social Security Number none

4. Sex: M. 5. Color or race: White 6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 28 1945

8. AGE: Years 1 Months ~~10~~ 3 Days 15 If less than one day hrs. min.

9. Birthplace: Elkton Cecil Co Md
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Charles R Rhoades
13. Birthplace: Middletown Del

MOTHER
14. Maiden name: Edna Simpson
15. Birthplace: North East Md

16. Informant: Charles Rhoades
Address: North East R F D #1 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-15-46 (month) (day) (year)

Cemetery or crematory: Methodist
Location: North East Md

18. Funeral director: Joseph R. Graves
Address: North East Md

19. 12/15 1946 Lia E. Owens
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 1946 at 4.15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death: Pneumonia Lobar.

Due to: Chicken Pox

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R L Dodson MD Medical Examiner for Cecil County
Address Elkton Md M. D. or other
Date signed 12-13-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77-c)

12015

CERTIFICATE OF DEATH

Reg. Dist. No. 920

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Pa County: Cambria

City or town: Portage

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John Calvin Richardson

3.(b) Social Security Number 216-07-0507

4. Sex: M.

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Mary Richardson

6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): Oct 3, 1895

8. AGE: Years: 51 Months: 2 Days: 28 If less than one day: hrs. min.

9. Birthplace: Portage Pa. (Town, county, and state)

10. Usual occupation: Miner.

11. Industry or business

FATHER 12. Name: Joseph Richardson

13. Birthplace: Pa.

MOTHER 14. Maiden name: Margaret Grief

15. Birthplace: Pa.

16. Informant: Mary Richardson

Address: Portage Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 3 1947 (month) (day) (year)

Cemetery or crematory: Portage

Location: Portage Pa.

18. Funeral director: H W Pippin

Address: Elkton, Md.

19. Jan 2 1947 (Date rec'd by registrar) F R Frazer (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 30 1946 at 2 a. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19

and that I last saw h alive on 19

Immediate cause of death: Acute Alcoholism — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R L Dockson M.D. M. D. or other

Address: Rising Sun Md. Date signed: 1-1-47

Medical Examiner Cecil County

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

12016

Reg. Dist. No. 940

1. PLACE OF DEATH:
County: Kent
City or town: North East Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Del. County: Newcastle
City or town: Wilmington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 109 Maryland Hill Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: William Henry Rutter

3.(b) Social Security Number: 221-09-7971

4. Sex: M
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of ~~husband~~ or wife: Nellie E. Rutter
6.(c) If alive, give age: 53 years
7. Birth date of deceased (mo., day, yr.): May 12, 1892
8. AGE: Years: 54 Months: 7 Days: 7 If less than one day: hrs. min.
9. Birthplace: Maryland (Church Hill) (Town, county, and state)
10. Usual occupation: Salesman
11. Industry or business
FATHER 12. Name: James T. Rutter
13. Birthplace: Maryland
MOTHER 14. Maiden name: Nettie Harper
15. Birthplace: Maryland
16. Informant: Mrs. Nellie E. Rutter
Address: 109 Marsh Rd Hill Crest, Del
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 23/46 (month) (day) (year)
Cemetery or crematory: Riverview
Location: Wilmington, Delaware
18. Funeral director: Herb Effem
Address: Elkton, Md
19. Dec 20 1946 Lydia V. Owens (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 19 1946, at 12:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...
and that I last saw h... alive on ..... 19...

	DURATION
Immediate cause of death: Compound fracture of skull.	
Fracture rt femur	
Due to: Right Humerus & fore arm.	
Due to: Fracture left Humerus + left tibia	
Other conditions: Contused abdomen & bruise.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 12-19-46
Where did injury occur? North East (City or town) Cecil (County) Md. (State)
Injured at home, farm, industry, public place (where?): Route 40
Means of injury: hit by auto. Injured at work?

23. SIGNATURE: R. C. Goodson M.D. M. D. or other
Address: Rising Sun Md Date signed: 12-19-46

Medical Examiner
Cecil County

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING